Michigan Department of Community Health
Response to Congressional Request for Information
CMS 2007 Medicaid Regulations

This document presents Michigan's response to the January 16, 2008 letter from Representative Henry A. Waxman representing the Committee on Oversight and Government Reform. This letter requested information for the Committee's investigation of the Bush Administration's regulatory actions on Medicaid.

As requested, Michigan is providing information that includes an estimate of the expected reduction in federal Medicaid funds over each of the next five years, and an estimate of the effect of this reduction on Medicaid applicants and beneficiaries. The time period covered includes five fiscal years from 2008 through 2012. Impact estimates assume a worst case scenario. Where more precise information is not available, the aggregate impact of inflation, utilization and caseload is trended at 3%.

In aggregate, over the next 5 years, Michigan estimates that federal Medicaid funds could be reduced by as much as $3.9 billion if all of these regulations were to be fully implemented and aggressively applied. Reductions of this magnitude would have a catastrophic impact on the individuals served by these programs. Especially hard hit would be children and persons with disabilities. It is impossible to envision a scenario other than one where eligibility groups are eliminated adding to the ranks of the uninsured. This inevitably leads to a deterioration of the condition of persons who would otherwise be receiving critical services, which in turn results in the use of more restrictive, more intensive and ultimately more expensive services.

A summary table which presents estimated reductions in federal Medicaid payments by fiscal year is provided at the end of this report.

Public Provider Regulation (CMS 2258-FC)

Michigan employs several financing mechanisms involving public providers, previously approved by CMS, all of which are clearly permissible under current laws and regulations. Most notable among these programs are (1) certified public expenditures (CPEs) to support disproportionate share (DSH) payments to hospitals which are currently considered to be public, (2) enhanced payments that facilitate access to services for Medicaid beneficiaries that are made to physicians and other practitioners employed by or under contact with public entities such as state universities with Medical schools and (3) DSH payments to hospitals, supported by intergovernmental transfers from counties, that help offset uncompensated care costs enabling Michigan's non-profit hospitals to better partner in community efforts to serve low income citizens who are uninsured.

Under an absolute worst case scenario, if CMS were to aggressively apply all parts of this regulation, Michigan would incur an annual reduction in federal Medicaid funding amounting to hundreds of million of dollars. The following table provides an estimate of how much the state could lose on a year-by-year basis over the next five fiscal years:

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 225,893
2009	$ 241,360
2010	$ 254,664
2011	$ 262,304
2012	$ 270,173
Total	$ 1,254,393

2008 data are trended at 3%. Additional fluctuation in federal dollars results from an increase in the federal matching rate from fiscal year 2008 to 2009, and from 2009 to 2010. The federal match rates are set for 2008 and 2009, while 2010 is an estimate. For fiscal years 2011 and 2012, it is assumed that the rate does not change.

All Medicaid beneficiaries could potentially be impacted by such a large reduction in federal support. Public hospitals and physician services, along with certain public health and mental health programs that receive Medicaid support, would be affected. These provider groups, along with county medical care facilities, would likely experience the greatest impact. Public hospitals are impacted by how the concept of “public” is defined in these regulations, as well as by limiting reimbursement to cost.

Aside from reductions in federal Medicaid funds, additional costs are likely to result from administrative burdens that would result from the implementation of these regulations. Of particular concern are documentation requirements related to CPEs, and protocols that have been (or will be) established to identify costs for public providers.

Because of the congressionally imposed moratorium on the implementation of the public provider regulation, CMS is not providing any guidance on how they intend to apply its various provisions. At the same time, they have indicated verbally that these regulations will apply retroactively to the beginning of the next fiscal year following the effective date of the regulation. For Michigan, these regulations would become effective on October 1, 2007.

Provider Tax Regulation (CMS 2275-p)

Michigan currently levies provider taxes, referred to as “quality assurance assessments,” on hospitals, nursing homes, Medicaid health plans and community mental health programs. These assessments, which have been authorized by state law, are applied only to permissible classes of providers as specified by federal laws and regulations. Expenditures that are supported by Michigan’s provider taxes have been approved by CMS.

All of Michigan’s quality assurance assessments are in compliance with current laws, and prior to issuance of the provider tax regulation as final, the state was also in compliance with all applicable federal regulations. Although compliance with the new provider tax regulation is presumed, the language is sufficiently ambiguous to allow CMS flexibility to construe almost any provider tax as impermissible.

The final version of the regulation did include a specific change that will reduce federal Medicaid payments to Michigan. This change involves the effective date for a mandatory reduction of the 6.0% provider tax safe harbor standard to 5.5%. Michigan was interpreting application of the new standard as beginning with the first state fiscal year following the January 1, 2008 effective date of this provision, which would have meant an implementation date of October 1, 2008. CMS has clarified their interpretation to require January 1, 2008 as the date when the lower maximum tax amount must be implemented. The cost to Michigan in federal Medicaid funding is approximately $10 million, applicable only to fiscal year 2008.

If any of Michigan’s quality assurance assessment programs are determine to be impermissible under this final regulation, then the particular class of provider impacted and all of the Medicaid beneficiaries who use the services delivered by that class of provider would potentially experience reduced access to these services.

It is becoming impossibly difficult for states to adjust plans and budgets to the rapidly changing regulatory landscape, especially one which does not appear to emanate from congressional action. A case in point on provider taxes is that Michigan is already facing a significant change when its HMO provider tax authority to include only Medicaid contracted HMOs expires at the end of FY 2009.

Graduate Medical Education (CMS 2279-P)

The purpose of rule is to clarify that costs and payments associated with GME programs are not expenditures for medical assistance that are federally reimbursable under Medicaid.

Michigan GME amounts to $180 million annually and is broken into two pools. These include a GME funds pool of 150.5 million that is based on number of residents and the amount of time they spend serving Medicaid beneficiaries, and $18.5 million for a primary care pool based on number of residents and the outpatient services that they provide to Medicaid beneficiaries. Both of these pools are supported with state general funds dollars. There is another special GME payment amounting to $11 million annually which supports psychiatric education programs.

The following table provides an estimate of how much federal Medicaid funding the state could lose on a year-by-year basis over the next five fiscal years:

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 104,464
2009	$ 108,365
2010	$ 111,009
2011	$ 111,009
2012	$ 111,009
Total	$ 545,855

If GME were eliminated, as indicated in the table above, Michigan would potentially lose up to $108 million in federal Medicaid funding during fiscal year 2009, and more in subsequent fiscal years. State match for this program is appropriated annually for this program at a constant level. Therefore, the amount of federal Medicaid funds received is generally impacted only by changes in the federal matching rate.

The elimination of graduate Medical education would significantly reduce the amount of money available to fund programs that train physicians, a scenario that will ultimately contribute to a future shortage of medical professionals in the state. In addition, it will reduce access to care for Medicaid beneficiaries who are served by major safety net providers that have relied on GME funding for these past 42 years.

Payment for Hospital Outpatient Services (CMS 2213-P)

This regulation revises the definition of outpatient services to align Medicaid with Medicare.

Michigan recently converted its outpatient reimbursement methodology to Medicare's outpatient perspective payment system (OPPS) structure. Furthermore, in order to obtain CMS approval for an outpatient supplemental payment during fiscal year 2005, the state was required by CMS to revise its outpatient upper payment limit (UPL) calculation methodology.

As part of that process, and consistent with what is reflected in the new regulation, the methodology that was developed to calculate the UPL (1) reflects a comparison of like services, (2) requires the use of the most recently filed Medicare cost report to calculate cost to charge ratios, and (3) limits the scope of Medicaid outpatient services to those typically and traditionally recognized as such.

Consequently, at least as far as its Medicaid program is concerned, Michigan is already in full compliance. Therefore, the state does not anticipate any reduction in federal funds as a result of this regulation.

Coverage of Rehabilitation Services (CMS 2261-P)

This regulation restricts the provision of habilitation services (as differentiated from rehabilitation services) to Medicaid recipients. Several programs and many beneficiaries, including many children, would potentially be impacted. It is particularly confounding and objectionable that this regulation harms children in a way that is discriminatory. Children who are delayed but who can achieve function are barred from receiving services because they technically cannot recover what they have not lost. This puts Medicaid in the position of favoring adults over children when EPSDT would suggest that Medicaid's bias would be otherwise.

Various (non-Mental Health) Programs

Several programs outside of the public mental health system, and the people they serve, would be impacted in Michigan. These programs include School Based Services, Children's Special Health Care Services, the Children's Waiver and other smaller programs. The majority of recipients whose services would be limited or eliminated by this regulation are children who receive services through the School Based Services program. Loss of federal Medicaid funds for school-based services will be addressed in another section of this report. However, there are approximately 15,000 beneficiaries not part of the school-based program who receive therapy services.

The worst case scenario under this regulation would result in either the state or beneficiaries/families becoming liable for the cost of medically necessary therapy services. Another likely result is that services would be reduced or not provided at all for some individuals.

The following table provides an estimate of how much federal Medicaid funding the state could lose on a year-by-year basis over the next five fiscal years:

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 21,497
2009	$ 22,142
2010	$ 22,806
2011	$ 23,490
2012	$ 24,195
Total	$ 114,130

Without these services, beneficiaries would potentially require institutionalization or would experience further regression as a result of their condition, both of which could end up costing both the state and the federal government more money.

Services for People with Developmental Disabilities Served by the Public Mental Health System

Almost 29,000 developmentally disabled adults and children living in community settings could potentially lose habilitation services under this regulation.

The following table provides an estimate of how much federal Medicaid funding the state could lose on a year-by-year basis over the next five fiscal years:

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 304,155
2009	$ 313,279
2010	$ 322,678
2011	$ 332,358
2012	$ 342,329
Total	$ 1,614,798

Michigan has 23,600 adult and 5,100 child Medicaid beneficiaries with developmental disabilities living in group homes, with their families, or in supported independent arrangements. These beneficiaries participate in daily community activities that include school, work, volunteering and recreation, and almost all of them would potentially be affected.

More than 72.9% of these individuals do not meet the criteria for ICF/MR services and therefore are not eligible for Michigan's 1915(c) home and community based waiver. However, these individuals do receive Medicaid state plan specialty services and supports and additional 1915(b)(3) waiver services to support them in the community. Under the proposed rehabilitation regulation, most would potentially lose access to the state plan specialty services and supports covered by the rehabilitation option.

Individuals who are enrolled in the home and community base waiver are also eligible to receive Medicaid state plan and 1915(b)(3) services. It is unclear from the proposed rule whether HCBW waiver enrollees would lose eligibility for state plan and 1915(b)(3) services that are considered “rehabilitative.”

Michigan citizens with developmental disabilities are active in their communities but require a range of support services such as transportation, personal assistance, skill-building and supported employment. Without the specialty supports and services, their living arrangements and their jobs in the community could not be sustained, and families caring for their children with disabilities could not be supported.

There are insufficient state general funds to replace the loss of the Medicaid funds for community rehabilitation services.

Payments of costs for school administrative and transportation services (CMS 2287-P)

Transportation services currently impact children age 0 to 26. Administrative Outreach services are available to all school aged children in the state. Of $22 million in total spending for these programs, transportation expenditures account for $3.1 million while administrative outreach accounts for $18.9 million.

The following table provides an estimate of how much federal Medicaid funding the state could lose on a year-by-year basis over the next five fiscal years:

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 22,000
2009	$ 22,660
2010	$ 23,340
2011	$ 24,040
2012	$ 24,761
Total	$ 116,801

If Medicaid funding for transportation is eliminated, the total cost of providing these services will be born by the local school districts.

If administrative outreach is eliminated, school-age children in Michigan will lose an ideal access site for linkage to medical, social and educational programs. Since children are mandated to attend school and since clinicians are already available in the school setting, this service is ideal for providing the proper referral to other health care programs. Without administrative outreach, some children in the state may experience delays in service provision, fragmented care or no care at all. If the appropriate program linkages do not occur, children could

end up in more intense, higher cost care. As a result, additional costs may be incurred both by the State of Michigan and by the federal government.

Case Management Services (CMS 2237-IFC)

Several Michigan programs are impacted by the new case management regulation.

School-based Services Program

The impact on children in Michigan would be the loss of continuity of care and student centered coordination of services. The population affected would be special education eligible children age 0 to 26.

The cost of funding school-based case management services will transfer to local school districts. Without federal Medicaid funding, these services likely would not be provided in the school setting.

The following table provides an estimate of how much federal Medicaid funding the state could lose on a year-by-year basis over the next five fiscal years:

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 35,441
2009	$ 36,504
2010	$ 37,599
2011	$ 38,727
2012	$ 39,889
Total	$ 188,161

Pursuant to current regulations, schools are mandated to provide school-based case management services. Under these regulations, funding responsibility will shift to school districts, and some services are likely to be terminated. Positions for Special Education Medicaid Coordinators at the schools will most likely be eliminated. In addition, since Special Education services are mandated, it is likely that General Education staff would have to be cut as a result of this revenue loss.

Children's Waiver

Michigan has a 1915(c) home and community based waiver for children with special health and mental health care needs. The loss of case management services would have a detrimental impact on the quality and availability of services provided to these recipients.

The following table provides an estimate of how much federal Medicaid funding the state could lose on a year-by-year basis over the next five fiscal years:

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 400
2009	$ 412
2010	$ 425
2011	$ 437
2012	$ 451
Total	$ 2,125

Children's Special Health Care Services

This program serves beneficiaries who meet a qualifying medical diagnosis that enables them to be enrolled into the Children's Special Health Care Services (Title V) program.

The following table provides an estimate of how much federal Medicaid funding the state could lose on a year-by-year basis over the next five fiscal years:

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 276
2009	$ 284
2010	$ 293
2011	$ 302
2012	$ 311
Total	$ 1,465

Many of these children have multiple health problems. Therefore, care coordination between health providers is essential. Without the care coordination that is achieved with case management, these children may not receive the appropriate referrals or care needed and thus may be provided with inappropriate care or duplicate services.

It is again ironic that this punitive narrowing of what qualifies as Medicaid reimbursable case management flies in the face of existing regulations that encourage Medicaid programs to use Title V (Children with Special Health Care Needs) programs as fully as possible to take advantage of their expertise in arranging and coordinating services for this special population.

Home Help Case Management

Michigan's home help program provides services that enable 55,000 people, most of whom have some form of disability, to live in their own homes.

The following table provides an estimate of how much federal Medicaid funding the state could lose on a year-by-year basis over the next five fiscal years:

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 11,600
2009	$ 11,800
2010	$ 11,900
2011	$ 12,000
2012	$ 12,100
Total	$ 59,400

Beneficiaries in the Home Help program currently receive two assessments by case managers per year. Case managers are familiar with Home Help program systems and how to authorize monthly service levels. Case managers unfamiliar with the system would have to go through a learning curve.

Implementation of this regulation would result in assessments having to be done by different assessors who would probably be less familiar with the needs of these individuals and with the program's structure. Loss of federal financing for this program could also impact the $220 million spent annually for these clients' home help services. Whether that expenditure would increase or decrease based on these proposed regulations is unknown at this time.

Office of Services to the Aging (OSA)

Targeted case management (TCM) is provided to individuals enrolled in the OSA Care Management Program that are age 60 plus, at risk of institutionalization, meet nursing facility level of care criteria, and are not enrolled in Michigan's home and community based waiver program. TCM is provided by a registered nurse to individuals with multiple, complex conditions in need of long term care services.

The following table provides an estimate of how much federal Medicaid funding the state could lose on a year-by-year basis over the next five fiscal years:

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 550
2009	$ 567
2010	$ 583
2011	$ 601
2012	$ 619
Total	$ 2,920

This regulatory change impacts both care management clients and program staffing. Impacted clients are individuals age 60 plus at risk of premature or unnecessary nursing home placement. Impacted staff include care managers at area agencies on aging.

There is an increased potential that individuals would seek Medicaid-funded long term care services in the more expensive institutional setting. Potential also exists that other systems will be strained trying to accommodate the needs of a growing population of recipients.

Mental Health & Substance Abuse Specialty Services and Supports

In Michigan, more than 68,000 Medicaid beneficiaries with serious mental illnesses, serious emotional disturbances, and developmental disabilities receive one of three types of case management services through the Medicaid specialty services and supports program. The three types of case management services are: targeted case management, supports coordination available through the authority of Section 1915(b)(3), and supports coordination available to persons enrolled in the 1915(c) waiver program for people with developmental disabilities. The total case management expenditures for FY'06 were $148,453,443.

While the state does not anticipate a loss of services as a result of the proposed rule, the new case management regulation will likely have a significant impact on how case management is administered at the local level. This may result in a change of case managers for beneficiaries and more required documentation.

It is unclear as to how much of a reduction, if any, would accrue to these programs as a result of this regulation.

Medicaid Regulations - Proposed and/or Under Moritorium
Estimated Impact on Michigan

			Reduced Medicaid (Federal Share in thousands)					
Regulation	Program	Comment:	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	Total
Public Provider	Multiple		$ 225,893	$ 241,360	$ 254,664	$ 262,304	$ 270,173	$ 1,254,393
Provider Tax	Hospitals, HMOs, Nursing Homes, CMH	All provider taxes permissible under current laws. Final reg released 2/22/08	$ 10,000					$ 10,000
GME	Teaching Hospitals		$ 104,464	$ 108,365	$ 111,009	$ 111,009	$ 111,009	$ 545,855
Hospital Outpatient	Hospitals	Reg not likely to impact Michigan Medicaid	$ -					$ -
Rehabilitation	Multiple		$ 21,497	$ 22,142	$ 22,806	$ 23,490	$ 24,195	$ 114,130
Rehabilitation	Developmental Disabilities	Applies to as many as 30,000 people who reside in community settings	$ 304,155	$ 313,279	$ 322,678	$ 332,358	$ 342,329	$ 1,614,798
School Based Services	Transportation and Administrative Outreach		$ 22,000	$ 22,660	$ 23,340	$ 24,040	$ 24,761	$ 116,801
Case Management	School Based Services		$ 35,441	$ 36,504	$ 37,599	$ 38,727	$ 39,889	$ 188,161
Case Management	Children's Waiver	About 400 children with serious mental and physical disabilities	$ 400	$ 412	$ 425	$ 437	$ 451	$ 2,125
Case Management	CSHCS		$ 276	$ 284	$ 293	$ 302	$ 311	$ 1,465
Case Management	Home Help		$ 11,600	$ 11,800	$ 11,900	$ 12,000	$ 12,100	$ 59,400
Case Management	Office of Services to the Aging		$ 550	$ 567	$ 583	$ 601	$ 619	$ 2,920
Case Management	Mental Health & Substance Abuse. No fiscal data available	Cost information not available. Do not anticipate loss of services, but impact on how services are delivered at the local level						$ -
			$ 736,276	$ 757,374	$ 785,296	$ 805,268	$ 825,836	$ 3,910,049

Actuarial Division
2/29/08

Provider Reg

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 225,893
2009	$ 241,360
2010	$ 254,664
2011	$ 262,304
2012	$ 270,173
Total	$ 1,254,393

GME

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 104,464
2009	$ 108,365
2010	$ 111,009
2011	$ 111,009
2012	$ 111,009
Total	$ 545,855

Rehab General

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 21,497
2009	$ 22,142
2010	$ 22,806
2011	$ 23,490
2012	$ 24,195
Total	$ 114,130

Rehab DD

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 304,155
2009	$ 313,279
2010	$ 322,678
2011	$ 332,358
2012	$ 342,329
Total	$ 1,614,798

School-based Admin and Transportation

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 22,000
2009	$ 22,660

2010	$	23,340
2011	$	24,040
2012	$	24,761
Total	$	116,801

Case Management - School-based Services

Fiscal Year	Estimated Reduction (in thousands)	
2008	$	35,441
2009	$	36,504
2010	$	37,599
2011	$	38,727
2012	$	39,889
Total	$	188,161

Children's Waiver

Fiscal Year	Estimated Reduction (in thousands)	
2008	$	400
2009	$	412
2010	$	425
2011	$	437
2012	$	451
Total	$	2,125

Children's Waiver

Fiscal Year	Estimated Reduction (in thousands)	
2008	$	276
2009	$	284
2010	$	293
2011	$	302
2012	$	311
Total	$	1,465

Home Help Case Mgt

Fiscal Year	Estimated Reduction (in thousands)	
2008	$	11,600
2009	$	11,800
2010	$	11,900
2011	$	12,000
2012	$	12,100
Total	$	59,400

OSA

Fiscal Year	Estimated Reduction (in thousands)
2008	$ 550
2009	$ 567
2010	$ 583
2011	$ 601
2012	$ 619
Total	$ 2,920